Health and Safety Specialists
(877) 914 – 3473 (FIRE)
(F) (845) 692 - 2402
help@firephysicals.com

Results of Medical Form

Fire Department: _____

Firefighter Name: _____ **Date:** _____

HEALTH & SAFETY SPECIALISTS is pleased to offer you onsite medical examinations. We hope that your exam is comfortable and provides you with the confidence of good health. If you are having blood work, please fill out an envelope so we may mail your results directly to your home. It should arrive within 10 days. Please use our contact information above if you have any questions.

OSHA Questionnaire _____

Eye Test _____

Hearing _____

Lung Function _____

EKG _____

Blood Pressure _____

Weight _____

Blood Work:

Comprehensive Chemistry, CBC, and Cholesterol _____

Prostate (age >40) _____

Blood Type _____

PPD/TB _____

Urine Drug Screen _____

Vaccines:

Hepatitis B Booster _____

Tetanus _____

Pneumonia _____

FIT TESTING _____

Initial Hepatitis B Series (3 Shots) _____

Flu Vaccine _____

Other:

***AFTER ALL ITEMS LISTED ABOVE ARE COMPLETED, THEN: MEDICAL EXAM _____

Firefighters Stress Test (All interior Firefighters and Responders over age 35) _____

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OSHA Respirator Medical Evaluation Questionnaire

Standard Title: Respiratory Protection
Subpart Number: I
Subpart Title: Personal Protective Equipment
Produced by USDOL OSHA - OCIS

Standard Number: 1910.134 App C
*Can you read (circle one): Yes/No

***Part A. Section 1. (Mandatory)** The following information must be provided by every employee who has been selected to use any type of respirator (please print).

*1. Today's date: _____

*2. Your name: _____

*3. Your age (to nearest year): _____

*4. Sex (circle one): Male/Female

*5. Your height: _____ft. _____ in.

*6. Your weight: _____lb.

*7. Your job title: _____

*8. A phone number where you can be reached by the physician who reviews this questionnaire (include the Area Code): _____

*9. The best time to phone you at this number: _____

*10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

*11. Check the type of respirator you will use (you can check more than one category):

*a. _____ N, R, or P disposable respirator (filter mask, non-cartridge type only).
*b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
*12. Have you worn a respirator (circle one): Yes/No

* If "yes", what type(s): _____

***Part A. Section 2. (Mandatory)** Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator :
(please circle "yes" or "no").

*1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes/No

*2. Have you ever had any of the following conditions?
*a. Seizures (fits): Yes/No
*b. Diabetes (sugar disease): Yes/No
*c. Allergic reactions that interfere with your breathing: Yes/No
*d. Claustrophobia (fear of closed-in places): Yes/No
*e. Trouble smelling odors: Yes/No

*3. Have you ever had any of the following pulmonary or lung problems?
*a. Asbestosis: Yes/No
*b. Asthma: Yes/No
*c. Chronic bronchitis: Yes/No
*d. Emphysema: Yes/No
*e. Pneumonia: Yes/No
*f. Tuberculosis: Yes/No
*g. Silicosis: Yes/No
*h. Pneumothorax (collapsed lung): Yes/No
*i. Lung cancer: Yes/No
*j. Broken ribs: Yes/no
*k. Any chest injuries or surgeries: Yes/No
*l. any other lung problem that you've been told about: Yes/No

*4. Do you currently have any of the following symptoms of pulmonary or lung illness?
*a. Shortness of breath: Yes/No
*b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
*c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
*d. Have to stop for breath when walking at your own pace on level ground: Yes/No
*e. Shortness of breath when washing or dressing yourself: Yes/No
*f. Shortness of breath that interferes with your job: Yes/No
*g. Coughing that produces phlegm (thick sputum): Yes/No
*h: Coughing that wakes you early in the morning: Yes/No
*i. Coughing that occurs mostly when you are lying down: Yes/No
*j. Coughing up blood in the last month: Yes/No
*k. Wheezing: Yes/No
*l. Wheezing that interferes with your job: Yes/No
*m: Chest pain when you breathe deeply: Yes/No
*n: Any other symptoms that you think may be related to lung problems: Yes/No

*5. Have you ever had any of the following cardiovascular or heart problems:
*a. Heart attack: Yes/No
*b. Stroke: Yes/No
*c. Angina: Yes/No
*d: Heart failure: Yes/No

*e: Swelling in your legs or feet (not caused by walking): Yes/No
*f: Heart arrhythmia (heart beating irregularly): Yes/No
*g. High blood pressure: Yes/No
*h. Any other heart problem that you've been told about: Yes/No

*6. Have you ever had any of the following cardiovascular or heart symptoms?
*a. Frequent pain or tightness in your chest: Yes/No
*b. Pain or tightness in your chest during physical activity: Yes/No
*c. Pain or tightness in your chest that interferes with your job: Yes/No
*d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
*e. Heartburn or indigestion that is not related to eating: Yes/No
*f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

*7. Do you currently take medication for any of the following problems?
*a. Breathing or lung problems: Yes/No
*b. Heart trouble: Yes/No
*c. Blood pressure: Yes/No
*d. Seizures (fits): Yes/No

*8. If you've used a respirator, have you ever had any of the following problems?
(**If you've never used a respirator**, check the following space and go to question 9):
*a. Eye irritation: Yes/No
*b. Skin allergies or rashes: Yes/No
*c. Anxiety: Yes/No
*d. General weakness or fatigue: Yes/No
*e. Any other problem that interferes with your use of a respirator: Yes/No

*9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

*Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained or breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

*10. Have you ever lost vision in either eye (temporarily or permanently): Yes/No
*11. Do you currently have any of the following vision problems?
*a. Wear contact lenses: Yes/No
*b. Wear glasses: Yes/No
*c. Color blind: Yes/No
*d. Any other eye or vision problem: Yes/No

*12. Have you ever had an injury to your ears, including a broken ear drum: Yes/No
*13. Do you currently have any of the following hearing problems?
*a. Difficulty hearing: Yes/No
*b. Wearing a hearing aid: Yes/No
*c. Any other hearing or ear problem: Yes/No
*14. Have you ever had a back injury: Yes/No
*15. Do you currently have any of the following musculoskeletal problems?
*a. Weakness in any of your arms, hands, legs, or feet: Yes/No

*b. Back pain: Yes/No
*c. Difficulty fully moving your arms and legs: Yes/No
*d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
*e. Difficulty fully moving your head up or down: Yes/No
*f. Difficulty fully moving your head side to side: Yes/No
*g. Difficulty bending at your knees: Yes/No
*h. Difficulty squatting to the ground: yes/No
*i. Climbing a flight of stairs or a ladder carrying more than 25 lb.: Yes/No
*j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

*Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

*1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No
If "yes" name the chemicals if you know them: _____
_____
_____

*3. Have you ever worked with any of the materials, or under any of the conditions listed below:
a. Asbestos: Yes/No
b. Silia (e.g., in sandblasting): Yes/No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
d. Beryllium: Yes/No
e. Aluminum: Yes/No
f. Coal (for example, mining): Yes/No
g. Iron: Yes/No
h. Tin: Yes/No
i. Dusty environments: Yes/No
j. Any other hazardous exposures: Yes/No
If "yes", describe these exposures: _____
_____
_____

*4. Have you been in the military services? Yes/No
If "yes", were you exposed to biological or chemical agents (either in training or combat): Yes/No

*5. Have you ever worked on a HAZMAT team? Yes/No
*6. Are you taking any other medications for any reason (including over-the-counter medications): Yes/No
If "yes", name the medications if you know them: _____

_____

*7. Have you ever received vaccination for Hepatitis B? Yes/No
If "yes", when was it last administered? _____

FOLLOW UP & PHYSICAL FORM

NAME: _____ **DOB:** _____

ADDRESS: _____ **PHONE:** _____

E-MAIL ADDRES: _____

_____

_____

PHYSICIAN NOTES:

PMHx: _____

PSHx: _____

Meds: y/n _____

Allergies: y/n _____ **Smoker: y/n** _____

Back Pain: y/n _____ PULSE OX _____ EYES R__ B__ L__

VITALS: BP _____/_____ **HR:** _____ **HT:** _____ **WT:** _____ **BMI:** _____

SKIN: _____ HEENT: _____ NECK: _____
NECK: _____ THYROID: _____ CARATOIDS: _____
LUNGS: _____ HEART: _____ PULSES: _____
ABD: _____ HERNIA: y/n EXTREMITIES: _____
JOINTS: _____ CLUBBING/CYANOSIS: Y/N
NEUROLIGIC: _____ BACK: _____
ADDITIONAL NOTES: _____

IMPRESSION: Normal Exam: _____ **Deferred:** _____

Problems: _____ Recommend: _____

_____ **Class "A" Firefighter** – Medically qualified for INTERIOR duties

_____ **Class "B" Firefighter** – Medically qualified for EXTERIOR duties

_____ **Class "C" Firefighter** – NOT qualified for EXTERIOR duties

The following restrictions apply: _____ Unable to lift more than ____ lbs.

Signed: _____